DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

QUESTIONS CALL: 1-800-999-1118

MEDICARE QUESTIONNAIRE FOR DISABLED WIDOW OR WIDOWER

NAME	DATE OF BIRTH	MEDICARE NUMBER
THEODORE PUBLIC	3/5/1963	123456789D

INSTRUCTIONS: This information will be read by a computer. Please print as shown below. Stay within the boxes. Use CAPITAL letters. Mark boxes with an X. USE BLACK OR BLUE INK.

EXAMPLE | A | B | C | | 1 | 2 | 3 | | | |

SECTION A - INFORMATION ABOUT YOU

1) Did you remarry after you started receiving Social Security checks?

YES [X] NO [ ] (If **NO, STOP**, go to Section B)

2) Are you getting any health coverage from your family member's **current** employment?

YES [X] NO [ ] (If **NO, STOP**, go to Section B)

3) How many employees, including your husband/wife, work for your family member's employer?

Don't know [ ] 100 or more [X] Less than 100 [ ] (If less than 100, **STOP,** go to Section B)

Please print the name of your family member's employer, and information about his/her group health plan in the spaces below:

FAMILY MEMBER'S NAME

FIRST: AMALIA

Middle Initial:

FAMILY MEMBER'S SOCIAL SECURITY NO.: 987 12 6543

LAST: PUBLIC

EMPLOYER NAME: BRAXTON INC

ADDRESS: 135 MAIN ST

CITY: KALAMAZOO STATE: MI ZIP: 49006

NAME OF GROUP HEALTH PLAN: BLUE HORIZONS

ADDRESS: 390 WEST MAIN ST

ADDRESS:

CITY: KALAMAZOO STATE: MI ZIP: 49016

GROUP IDENTIFICATION NUMBER: 123

POLICY NUMBER: 987126543

OMB NO. 0938-0214

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SAMPLE